Brokers and Agents and Health Insurance Exchanges

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As the Affordable Care Act is implemented, reaching and enrolling the millions of newly eligible people, helping people switch plans, and educating consumers on the new protections of the law will be a major task that will require all hands on deck. The Congressional Budget Office anticipates that 30 million uninsured people will gain coverage under the Affordable Care Act by 2022. Nearly half of them will gain coverage in 2014.[1] People will need help enrolling in plans, figuring out their eligibility for premium tax credits, and in some cases, switching to another plan that offers better benefits or help with premiums. In addition, consumers will want help understanding the new rights and protections offered by the Affordable Care Act.

Much of this new enrollment will take place through health insurance exchanges, which will begin accepting applications in October 2013. These exchanges will be regulated marketplaces where consumers and/or small businesses can shop for insurance and readily compare standardized plans. Additionally, low- and middle-income consumers will be able to apply for premium tax credits and for Medicaid and CHIP through the exchanges. Exchange rules recognize the importance of getting lots of different helpers in the enrollment process: traditional health insurance brokers and agents will continue their work and, appropriately, other entities and agencies will also help with outreach and enrollment. Yet, besides making sure that everyone who has the potential to reach consumers does so, states will have the major responsibility of making sure that consumers get accurate and complete information about their health insurance choices. In this uncharted territory, it will be important that states think about how brokers and agents, particularly, interact with the exchange.

With regard to brokers and agents (which are referred to generally as "producers"), states will need to:

- actively monitor and regulate marketing practices and step in to promptly stop any misleading or deceptive marketing;
- ensure that incentives brokers and agents receive are appropriate to guide consumers to good enrollment choices;
- ensure that consumers know if agents and brokers receive payment for enrolling them in certain plans and could be providing biased information;
- develop training programs and update competency exams to make sure that brokers and agents can properly explain exchange plans, tax credits, and public program options; and
- ensure that consumers who use brokers or agents will also be informed about how to contact their state's exchange and get further information from the exchange's website.

This paper is intended to give advocates some background information about brokers and agents. This information will help you determine whether changes are needed in your state's training, regulation, or oversight of agents and brokers to ensure that your state has adequate consumer protections. It defines terms, explains what the final exchange rules say about agents and brokers, and then discusses some of the issues that advocates and states may want to consider.

The Roles of Brokers, Agents, and Producers

Although the terms "broker," "agent," and "producer" are often used interchangeably, the National Association of Insurance Commissioners distinguishes their roles as follows:

- **Brokers** act on behalf of the consumer. They can be compensated by the consumer or receive compensation from an insurance company.
- **Agents** are loyal to an insurance company and sell, solicit, or negotiate insurance on behalf of the insurer. They are compensated by the company (or companies) only. An "independent agent" is affiliated with more than one company. A "captive agent" works for or on behalf of one insurance company. (When you buy a policy directly from an insurance company, you are probably going through an in-house agent.)
- **Producer** is a broader term that encompasses both agents and brokers. A producer is defined as someone who sells, solicits, or negotiates insurance.

Other Enrollment Assistance Resources

In addition to brokers and agents, other entities commonly play a role in health insurance plan outreach and enrollment. For example, State Health Insurance Assistance Programs (often called SHIPs) help Medicare beneficiaries understand their Medicare plan options and enroll. Government agencies, such as those that administer the Medicaid and Children's Health Insurance Programs, help people sign up for those benefits, and community-based organizations also assist with Medicaid and CHIP enrollment. Under the Affordable Care Act, these entities will also help applicants who don't qualify for Medicaid or CHIP get coverage and premium assistance through the exchange. Some consumers may select their plans as they apply for coverage, and others may do it in a separate step. Under the Affordable Care Act, navigators, consumer assistance programs, and other consumer-help entities will each have a role in helping consumers enroll in exchange plans and resolve any questions or problems they encounter.

This paper does not delve into issues concerning navigators—a forthcoming Families USA publication will discuss navigator program design—but it is useful to keep in mind how navigators are distinct from agents and brokers. The Affordable Care Act requires exchanges to establish a navigator program, using entities that have, or could readily form, relationships with people likely to be qualified to enroll in plans through an exchange. The navigator program will conduct public education, distribute "fair and impartial information" concerning enrollment, premium credits, and cost-sharing reductions; facilitate enrollment; provide referrals to consumer assistance resources if problems arise; and provide information in a manner that is culturally and linguistically appropriate. As noted in the next section, exchanges can use various types of entities to deliver navigator services. They may elect to use agents and brokers who agree to forego commissions for health insurance sales as one type of navigator, but exchanges must always designate at least one community- or consumer-focused nonprofit as a type of navigator.

The Final Exchange Rule and Brokers and Agents

The Department of Health and Human Services (HHS) published its final rule for the establishment of health insurance exchanges in the March 27, 2012, Federal Register. Consumers who meet income requirements and do not qualify for Medicaid or do not have other affordable coverage options may be eligible for premium tax credits that help them pay for qualified health plans sold in the exchange. HHS's final rule addresses both the governance of an exchange and how brokers and agents can assist with enrollment.

- **Exchange boards:** The majority of voting members on the governing board of an exchange can't have a conflict of interest. Members with a conflict include "representatives of health insurance issuers or agents or brokers." This provision will limit the number of brokers and agents on exchange boards. (45 CFR §155.110)
- **Exchange consultation:** The exchange must regularly consult with a number of types of stakeholders, including agents and brokers. (45 CFR §155.130)
- **Enrollment by agents and brokers:** Agents and brokers can assist with qualified health plan enrollments without being navigators, if states permit this. An agent or broker that enrolls individuals in qualified health plans through an exchange must first enter into a formal agreement with an exchange. At a minimum, the agreement must require the producer to register with the exchange, receive training about qualified health plans and about insurance affordability programs, and comply with privacy and security standards. When an agent or broker enrolls someone in a qualified health plan through the exchange, the agent or broker must ensure that the applicant completes the application on the exchange website and completes the eligibility verification process. Ultimately, the exchange—not the agent or broker—transmits enrollment information to the selected plan. If a producer's website is used to display the choices of qualified health plans, that website must meet certain standards, including that it display all of the qualified health plans offered by the exchange. (45 CFR §155.220) The interim final federal rule says that agents and brokers that meet certain standards (including having an agreement with the exchange) can also assist individuals in applying for advance premium credits and cost-sharing reductions.

- **When brokers and agents can act as navigators:** "Navigator entities" receive grants from the exchange to carry out a number of duties: (1) they are experts in eligibility and enrollment through the exchange, and they provide public education about the exchange; (2) they provide fair, accurate, and impartial information and services that must "acknowledge other health programs" (We understand that to include Medicaid and CHIP, for example, in addition to plans sold in the exchange.); (3) they facilitate selection of a qualified health plan (see "Qualified Health Plans and the Exchange" for more information on qualified health plans); (4) they refer to consumer assistance programs and appropriate agencies when enrollees have a complaint, grievance, or question about their health plan, covered benefits, or a determination made by their plan; and (5) they provide culturally and linguistically appropriate information to consumers. Navigators must receive training that is specific to their duties.

  Exchanges must award navigator grants to at least two types of entities. One must be a community- or consumer-focused nonprofit group. The other entity may be any of seven other types specified in the rules, one of which is "licensed agents and brokers." However, agents and brokers who serve as navigators cannot receive any compensation from health insurers, either directly or indirectly, for enrolling individuals or employees in health plans in or out of the exchange. (45 CFR §155.210) The preamble of this rule clarifies that exchanges cannot require all navigators to be licensed as agents or brokers, or to hold errors and omissions insurance (a type of liability insurance that may pay an agent or broker's losses and legal fees if their erroneous advice caused a client financial harm).

Qualified Health Plans and the Exchange

Qualified health plans offer a certain standardized package of benefits and meet other requirements so that they can be sold in an exchange, the regulated marketplace in each state where people can compare plans and shop for coverage. Qualified health plans must meet exchange standards for provider networks, marketing, accreditation, and other health plan factors. In order to shop in an exchange, people must: be residents of the area served by the exchange; be citizens, nationals, or lawfully present; and not be incarcerated. Federal law does not prohibit insurers from offering plans, including qualified health plans, outside of an exchange. However, it is possible that some states will require individual and/or small group health insurance be sold through an exchange as the only marketplace.

If people enroll in a plan through the exchange and verify their incomes, low- and moderate-income individuals and families who meet income requirements and do not have other affordable coverage options may receive premium tax credits and cost-sharing assistance for use with a qualified health plan. They will not receive that assistance if they enroll in plans outside of the exchange.

Broker and Agent Issues that Advocates and States Should Think About

Brokers and agents can be an important resource for outreach and enrollment. However, as the health insurance market changes, states and advocates should think about whether the state's existing regulation, oversight, and training requirements for agents and brokers are still sufficient, or whether they should be updated to better protect consumers.

Revisiting Regulation and Oversight of Marketing Practices

All states already have laws permitting only licensed agents or brokers to sell health insurance. (Other entities can give impartial information about insurance options, but only agents and brokers can promote one company over another and make sales.) Licensure ensures that agents and brokers have some basic training and have passed an exam demonstrating their knowledge of insurance regulation, health insurance concepts, and policy terms. Licensure gives states a way to intervene—by revoking a license, and thereby the legal authority to sell insurance, for example—if producers mislead or deceive consumers. Further, it gives states the power to stop an unlicensed, unqualified person from fraudulently selling products, including those products that may not even really be health insurance.[2] A national database (http://nipr.com/) helps states determine whether a producer is licensed in another state and is in good standing. States and community groups should educate consumers to ask whether an agent or broker that is attempting to sell them insurance is licensed.

States and exchange boards may want to set further parameters on marketing. For example, they may wish to ban door-to-door marketing and unsolicited marketing of qualified health plans ("cold calls"). It is difficult for states or insurance companies to monitor what an agent says in a door-to-door presentation, and in other contexts, this marketing has proven ripe for abuse: Persuaded by a door-to-door salesperson that they had to take action, consumers have signed up for plans that they did not need or did not understand.[3] Similarly, when consumers receive unsolicited phone calls, they cannot easily identify whether the caller legitimately sells health insurance. Since consumers should not be giving personal or financial information to a caller who may or may not be legitimate, it is best to ban unsolicited marketing and educate consumers not to talk to plan salespeople unless they have initiated the call. Exchanges may also want to require that all plan marketing materials, including those created by agents or brokers, are subject to advance review by a regulator. States should require that any marketing gifts be of nominal value and that any marketing materials that list an agent's or broker's phone number also provide the phone number for the exchange (and the plan, if applicable). Federal rules for Medicare and Medicaid plans include these sorts of marketing protections and could thus serve as an example for exchange marketing protections.[4]

It is not enough just to set marketing rules; it is also important that the state and plans vigilantly oversee marketing practices of agents and brokers. Plans are responsible for the work of contracted agents and brokers and should ensure that they are properly trained and understand the products they are marketing. States and plans should both monitor marketing practices and take action if complaints arise. They should watch for complaints that consumers misunderstood their plan, its provider network, or its premiums and cost-sharing obligations since these can be signs of improper or misleading marketing.[5]

Ensuring that Agents and Brokers Give Consumers Information about All Available Exchange Plans

It is important for consumers to understand all of their options for coverage in an exchange, especially because premium assistance will cover more of their costs in some plans than in others. States could use various methods to ensure that consumers know about and understand all of their options. One way would be to require brokers and agents to sell all exchange plans.[6] (The exchange rules already require this of brokers who use their own websites to market qualified health plans, but states could extend the requirement to brokers and agents that sell products in person.) For example, if an exchange is paying brokers directly, the exchange's contracts and agreements with brokers could require them to sell all exchange plans. Alternatively, states could require that qualified health plans that participate in the exchange all use a common set of brokers. Even if agents and brokers do not have to sell all plans, a state might require agents and brokers that sell exchange plans to explain which plans they are selling, disclose that these are not the only plans available through the exchange, and describe where consumers can get information about the remaining exchange plans. In this case, advocates might want to work with states to draft a prominent, easy-to-understand notice and script that brokers and agents must use to provide this information to consumers and small businesses.

Broker and Agent Compensation

Most states do not have rules about how brokers or agents are compensated, although they may have rules that require that certain brokers disclose that they are being compensated by an insurer. Compensation structures vary among insurers. Often, insurers pay agents and brokers a percentage of the annual premiums that they bring in. They may pay a higher amount for first year sales, and they may pay bonuses for bringing in a high volume of business or particularly profitable business, such as larger groups of relatively healthy enrollees. Agent trade associations report that compensation methods are changing in some markets and that, instead of paying a percentage of premiums, insurers are increasingly paying producers flat fees per member or per employee per month.[7]

A study of states' insurance market reforms over a decade ago found that agents played a critical role in the success of those reforms. If agents were not paid to sell guaranteed issue products but were paid to sell other health insurance, enrollment in the guaranteed issue products suffered; and when agents were compensated at a lower percentage of premiums for selling insurance to a very small business than for a larger business (despite the fact that servicing small groups requires the most work for brokers for the amount of premium earned) enrollments by these very small businesses suffered.[8]

In the context of exchanges,[9] states will want to work toward several goals and strategies related to compensation can help. They will want to do the following:

1. Maximize enrollment.
2. Make sure that agents and brokers do not undermine the exchange by directing consumers that could benefit from exchange coverage to policies outside the exchange.
3. Make sure that a mix of people with various health needs enroll in each exchange plan and that compensation structures don't drive enrollments to particular plans for reasons other than what is in consumers' best interests.
4. When it is open enrollment season, producers can help consumers change plans if their plan is no longer meeting their needs, but states may wish to discourage many plan changes, known as churning, unless changing plans is in the consumer's best interest.

States could use a range of methods pertaining to compensation to accomplish the above goals. For example, a state exchange could elect to pay agents and brokers a flat fee for selling exchange policies rather than having each insurer pay the agents and producers themselves. This is a strategy that is used by many state high-risk pools, by the federally run Pre-Existing Condition Insurance Plan (PCIP), and by the Massachusetts Connector and the Utah Health Exchange (state exchanges that predated the Affordable Care Act). However, advocates and states should be aware of the potential pitfalls to this approach: If the fee for selling exchange policies is less than typical compensation for selling policies outside of the exchange, exchange plan enrollment could suffer. Another method states could use is to have each insurer pay producers but to set some parameters: States could require that compensation for selling exchange plans be equal to compensation for plans outside the exchange, that compensation structures not lead to discriminatory sales practices and not be based on the health of the enrollee, or they could set some ranges on permissible compensation. Regulating compensation is likely to be a politically charged issue; agents and brokers are already concerned that the health care law will cause insurers to reduce the commissions they pay them. As a result, states and consumer advocates should think carefully about the best way to accomplish their goals. They should point out that prohibiting discriminatory practices need not reduce compensation.

Before weighing in on how or whether your state might regulate or set compensation for agents and brokers enrolling people in exchange plans, you may want to ask your state to gather some information on the volume of individual and small group health insurance business now handled by producers, and on how producers are typically compensated in your state. Some of this information may be proprietary, but your state should be able to get some information through meetings and surveys.[10]

If, for example, you find that most small businesses now purchase health coverage through brokers and agents, you might want to make sure that those producers will receive appropriate compensation to sell health plans through the SHOP (Small Business Health Options Program) exchange. Otherwise, your state's SHOP exchange may find itself with few enrollees and an adverse selection problem. If, on the other hand, producers are not selling much individual health insurance, you may want to consider whether producers or other community entities will be most important in reaching and enrolling individuals in the exchange. If you are in a state where a high-risk pool or the Pre-Existing Conditions Insurance Plan paid agents and brokers a flat fee for enrollments, you can ask how significant producer-initiated enrollments have been in these markets and whether the use of flat fees made a difference to enrollment.

Other compensation policies that states and advocates may want to consider are as follows:

- **Setting rules about compensation for first-year sales versus future sales:** Often, brokers are paid a higher rate for initial enrollments than for renewals, because initial enrollments require more work. If initial enrollment fees are much more lucrative, it may incentivize agents and brokers to help people change plans each open enrollment period, even when it is not in their best interest to do so. Prior to 2008, consumer advocates and states complained that agents and brokers encouraged seniors to switch Medicare Part D plans or switch to Medicare Advantage or private Medicare fee-for-service plans each open enrollment season, even when it was not in their best interest. They said that this churning was encouraged by the fact that agents and brokers were paid a much higher rate for new sales than for renewals. The federal government eventually capped the amount that initial sales compensation could vary from renewal compensation for Medicare plans and required that plans take back any commissions paid if beneficiaries rapidly disenrolled from a plan.[11]

- **Creating payment structures that encourage marketing to very small groups:** When agents and brokers are paid a percentage of premiums or fees per employee enrolled, they obviously get more money by selling to a large employer than to a small employer. On top of that, in the past, some insurers have actually paid a higher percentage of premiums for sales to larger groups.[12] However, very small businesses are especially likely to lack health insurance, and so to incentivize sales to these businesses, broker and agent compensation should not vary in small group markets unless it is reciprocally related to the group size. States such as Maryland,[13] Texas,[14] and Utah[15] required this even before federal health reform was enacted. Likewise, exchanges should target very small groups for outreach and enrollment assistance. States, exchange boards, and health plans should consider agent and broker payment structures that will encourage outreach to very small groups.
- **Making sure compensation for selling within the exchange and outside of the exchange is similar:** If producers are typically paid more to sell plans outside the exchange than they are to sell exchange plans, they may steer customers to the outside market, undermining the viability of the exchange. To combat this problem, as discussed earlier, exchanges setting their own compensation structure for producers should be mindful of the compensation producers receive on the outside market. California and the Pacific Business Group on Health learned this lesson when they operated small group purchasing pools from 1993 to 2006.[16] Similarly, if exchanges allow qualified health plans to set agent and broker compensation structures, they may want to require that those plans pay the same amounts to agents and brokers for selling products in and outside of the exchange.
- **Reviewing a plan's producer compensation schedule to ensure that incentives are appropriate:** States that do not require a particular compensation structure for agents and brokers might still want to require that plans' compensation structures results in appropriate, informed enrollments. Thus, states may want to review the compensation structure as well as each plan's overall marketing strategy to ensure that they are not designed to inappropriately steer enrollees into certain plans or inappropriately reward producers for enrolling certain individuals or groups instead of others. (Analogously, the federal Centers for Medicare and Medicaid Services now has the authority to review Medicare plans' producer compensation structures.[17]) States should consider reviewing compensation structures and marketing strategies before plan marketing begins and also reviewing them post-enrollment if actual enrollment patterns appear to indicate steering.

Informing Consumers about Possible Biased Guidance

The fees that an agent or broker receives from one insurer as compared to another or for selling one type of policy as compared to another may influence the producer to sell certain policies more vigorously. But consumers may not be aware when brokers and agents have financial incentives that may bias their advice. They may assume that if they are presented with multiple options, the agent or broker is guiding them to the policy that is in their best interest. Current state laws vary as to whether they require some or all licensed agents and brokers to disclose to consumers that they are compensated by insurers and the amount or method of compensation.[18] Some states require agents and brokers to have consumers sign a form that explains that the agent or broker has received compensation from an insurance company. Other states instead require the agent or broker to sign a form attesting that they disclosed this information to a consumer. In some cases, if the agent or broker will receive a bonus for bringing in a large volume of business or profitable business, that must be disclosed too. Still, other states have no rules requiring health insurance agents and brokers to disclose how they are compensated.

State disclosure requirements predated the Affordable Care Act, so the disclosures likely do not include all the information that a consumer might need before deciding whether to buy an exchange plan through a producer. If the state allows the agent or broker to receive varying commissions from different exchange plans, the consumer should know that they might have financial incentives to steer him or her to particular plans. Additionally, as mentioned above, a consumer should know if there are plans available in the exchanges that are not being sold by a particular agent or broker. Further, consumers should know the following:

1. Which exchange plans offer cost-sharing assistance;
2. That an online calculator is available to help them determine their premium share and cost-sharing obligations in various plans after the tax credit and cost-sharing assistance;
3. That they can enroll directly through the exchange if they don't want to use an agent or broker; and
4. That in addition to or instead of using an agent or broker, they can get help from a navigator who is not paid by plans and who is impartial.

Moreover, states should think about when the consumer needs the information and how to make any disclosure notices easily understandable. Signing a disclosure form at the time the consumer enrolls in a plan is too late in the process to give the consumer timely notice. Perhaps agents and brokers should present some standardized disclosure information both orally and in writing as they begin their presentations. If an agent or broker uses the exchange's web portal with consumers, the portal will help to provide the necessary information. However, if the agent or broker is on the phone with the consumer or in another setting where the consumer cannot actually view the web portal, they may not get the same information. States should think about any additional notice these consumers might need and how the state can be sure that the consumer has received notice.

Additional Training for Brokers and Agents

All states require brokers and agents that sell life and/or health insurance to be trained and pass an exam before they are licensed. Most states have "reciprocity agreements" whereby they agree to license non-resident producers who are licensed and in good standing in another state without further restrictions or qualifications. However, state training and continuing education requirements for resident producer licensure vary.[19] States should enhance the training requirements for agents and brokers who sell exchange plans. The federal rule requires that a broker participating in the exchange "receives training in the range of QHP [qualified health plan] options and insurance affordability Programs (45 CFR §155.220(d))." Thus, states should require some training on premium tax credits, advance premium tax credits, cost-sharing help, online exchange enrollment tools, enrollment through the exchange in public programs (and some basic information about public coverage programs that are not handled by the exchange, such as Medicare, veteran's benefits, and Medicaid for seniors and people with disabilities), how small businesses purchase insurance plans through the SHOP exchange, and small business tax credits.

Information on Exchange Websites about Brokers and Agents

Some exchange websites may list licensed brokers and agents who can help consumers with enrollment. This could be a useful function as it helps consumers identify legitimate brokers and agents and helps consumers understand what products they are selling. However, exchange websites should make it clear that brokers and agents are not the only source of help with exchange plan enrollments. They can do this by also including lists of navigators, making it clear wherever agents and brokers are listed that they are not the only source of help nor are they necessarily impartial (unless the state requires them to sell all exchange plans and be paid the same amount for enrollment in each), and by including contact information for the exchange and for health plans.

Information on Agent and Broker Websites

Although CMS is still weighing public comments on some parts of this rule, the interim final rule says that someone wishing to receive cost-sharing reductions and/or premium assistance in a qualified health plan must use the exchange's website to verify eligibility and apply for enrollment through the exchange, but can use producer's website to select a qualified health plan. In that case, the producer's website must provide the consumer the opportunity to view all qualified health plans, display all required data, and allow the consumer who is using the website to withdraw and use the exchange website instead at any time. Also, the website should not provide financial incentives, such as gifts or rewards for picking particular plans. However, the federal rule is not explicit about details such as how or in what order the required plan data must be displayed.

A recent study of some existing health plan comparison websites showed that the display of information matters to consumers' choices. Plan comparison websites often give consumers options of how they want to see plans sorted (e.g., by premium price, by bestselling plans, or by other variables.) However, producer and government websites differ in how they first display plan information before the consumer selects a sorting option. The study found that websites' default sorting options strongly influenced consumers' choices.[20] This is true even when the website provides alternate options for how to sort comparative information. Thus, states may want to consider how broker's and agent's websites may display information to ensure that sorting options do not influence consumers to select plans based on factors other than what is in their best interests. For example, states may wish to guide consumers to think about cost and quality first, rather than a plan's popularity or a more arbitrary sorting method. Similarly, the website shouldn't hide some of the exchange plan choices or make it hard to navigate the full list.

It is also important that consumers know when they are on an official government-sponsored website and when they are on the website of a private entity. Thus, exchanges may wish to establish and trademark an easily recognizable logo or take other steps to stop and prevent impostor exchange web portals.

Conclusion

Many entities will need to work together to achieve successful enrollment in health coverage under health reform. Agents and brokers will play an important role in this process: They already have experience with enrollment and know how to reach some segments of the population, and states already have some mechanisms in place to license and certify them. Some agents and brokers already have websites that compare health plans. But while these things provide some building blocks toward successful enrollment, they are not enough. Insurance options and enrollment systems will be different in 2014, so agents and brokers (as well as other entities) will need more training. Though agents and brokers reach some segments of the population, many people and businesses do not have insurance. Other segments of the population, such as people whose primary language is not English, or individuals in some neighborhoods or economic strata, may not be reached by agents and brokers at all. People who are reached by agents and brokers (or by their websites) may not know if they are getting complete information about their insurance choices or if information is biased due to the producer's financial arrangements with insurers. Health insurance producer licensing and certification programs pre-dated the Affordable Care Act, so certification does not yet show that a producer has the requisite knowledge to assist consumers with a reformed health insurance market.

In this new world of health insurance exchanges, states may take a variety of approaches to the use of agents and brokers. Some state exchanges may want to pay agents and brokers themselves so that they can require them to provide impartial information about all health plans sold through the exchange. Other state exchanges may decide to leave agent and broker payment arrangements to insurers, but they may still take additional steps to regulate and oversee agents' and brokers' behavior in a health insurance exchange. All states should plan for full-scale enrollment efforts over the next few years, and should develop concerted efforts, involving many different players, to reach the uninsured and underinsured.

Resources

California's Exchange Board

Individual Market: Agent Payment Options
http://www.healthexchange.ca.gov/BoardMeetings/Documents/July_19_2012/VIII-C_CHBE-BRB_AgentCompensation_07192012.pdf)

Small Employer Health Options Program (SHOP agent strategy starts on page 29)
http://www.healthexchange.ca.gov/BoardMeetings/Documents/June12_2012/CHBE-SHOPExchange-BoardOptions-05-18-12FINAL.pdf

The Maryland Health Benefit Exchange Navigator Advisory Committee

Navigator Certification and Insurance Producers Authorization Regulations Recommendations
http://dhmh.maryland.gov/exchange/pdf/Navigator%20Certification%20and%20Insurance%20Producer%20Authorization%20Regulations%20Recommendations_73012.pdf

July 30, 2012 Meeting (discussing navigator certification and producer authorization regulations)
http://dhmh.maryland.gov/exchange/SitePages/Navigator%20July%2030%20Meeting.aspx

The National Association of Insurance Commissioners

Draft *Marketing and Consumer Information White Paper: Navigators, Agents and Brokers, Marketing and Summary of Benefits and Coverage* (adopted by the Exchanges Subgroup on July 26, 2012)
http://www.naic.org/documents/committees_b_exchanges_120626_marketing_consumer_information_white_paper.pdf

Nevada's Silver State Health Insurance Exchange Consumer Assistance Advisory Committee

July 25, 2012, meeting and background materials (discussing training, certification, and compensation for producers and navigators in the exchange)
http://exchange.nv.gov/Meetings/July_25,_2012_Meeting_Attachments_CA/

Oregon Health Insurance Exchange Corporation

April 2012 meeting (discussing recommendations for an Agent Management Program, beginning on page 18)
https://orhix.org/pdfs/board/4_12_12_board_packet.pdf

State Reform

Discussions and papers from various states' health reform implementation activities
statereforum.org

Endnotes

[1] Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act, Updated for the Recent Supreme Court Decision* (Washington: CBO, July 24, 2012), available online at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf.

[2] The federal Gramm-Leach-Bliley Act requires states to either have uniform laws or reciprocal arrangements for licensing. Many states have thus adopted a model licensure act promulgated by the National Association of Insurance Commissioners. For a brief history, see the presentation by Sarah Heidenreich, National Association of Insurance Commissioners Legal Counsel, "Maintaining Tradition: History/Framework of Producer Licensing," (Kansas City, 2012), available online at http://www.naic.org/ereg/presentations/PL_200.pdf.

[3] Families USA Foundation, A Guide to Marketing and Enrollment in Medicaid Managed Care (Washington: Families USA, June 1997).

[4] Centers for Medicare and Medicaid Services, *Final 2013 Medicare Marketing Guidelines* (Baltimore: CMS, 2012), available online at http://www.cms.gov/Medicare/Health-Plans/ManagedCareMarketing/Downloads/2013-Medicare-Marketing-Guidelines.zip; 42 CFR § 438.104 and 42 CFR §422.2268.

[5] Experience with Medicare marketing problems in 2005-2007 is instructive. See: National Association of Insurance Commissioners, Senior Issues Task Force, *State Survey on Medicare Marketing Issues Preliminary Results* (Kansas City, MO: NAIC, June 2007), available online at http://www.naic.org/documents/committees_b_senior_issues_medpp_070911_survey_summary.pdf; David Lipshutz, Paul Precht, and Bonnie Burns, *After the Goldrush: The Marketing of Medicare Advantage and Part D Plans* (Sacramento: California Health Advocates and the Medicare Rights Center, January 2007), available online at http://www.cahealthadvocates.org/_pdf/advocacy/2007/AfterTheGoldrush.pdf.

[6] States could decide if different requirements would apply to captive agents that work for just one insurer and who don't make unsolicited sales.

[7] Letter from the Council of Insurance Agents and Brokers, Independent Insurance Agents and Brokers of America, The National Association of Health Underwriters, and National Association of Insurance and Financial Advisers to Kevin McCarty, Chair, National Association of Insurance Commissioners Professional Health Insurers Advisers Task Force, March 21, 2011.

[8] Mark A. Hall, "The Role of Independent Agents in the Success of Health Insurance Market Reforms," *78 Milbank Quarterly* 23, no. 1 (2000), available online at http://www.rwjf.org/files/research/Hall.%2078-1.pdf.

[9] States may want to look at producer compensation rules for other products too, including for stop-loss policies that may adversely affect their small group markets.

[10] The National Association of Insurance Commissioners, for example, worked with the National Association of Health Underwriters to gather national information about producer compensation in 2011 that blinded specific companies' practices. National Association of Insurance Commissioners Health Care Reform Actuarial (B) Working Group, Report Regarding Producer Compensation in the PPACA Medical Loss Ratio Calculation (Kansas City, MO: NAIC, May 26, 2011), available online at http://www.naic.org/documents/committees_b_110607_hcrawg_report.pdf.

[11] 42 Code of Federal Regulations §422.2274, published in the *Federal Register*, Vol. 73, No. 182, Thursday, September 18, 2008, pp. 53226-54254, available online at http://www.gpo.gov/fdsys/pkg/FR-2008-09-18/pdf/E8-21686.pdf.

[12] Mark A. Hall, op. cit.

[13] Maryland's law, amending 15-1206 of its Insurance Statute, available online at http://mlis.state.md.us/2002rs/billfile/hb0085.htm.

[14] Texas House Bill 471, enacted in 2001, available online at http://www.legis.state.tx.us/BillLookup/Text.aspx?LegSess=77R&Bill=HB471.

[15] Utah Administrative Code Rule R590-270, available online at http://www.rules.utah.gov/publicat/code/r590/r590-207.htm#T5.

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Individual Market: Agent Payment Options

August 16, 2012

Summary

The California Health Benefit Exchange has taken an "all hands on deck" approach for addressing the challenges of enrolling millions of Californians in new affordable coverage options. To complement the proposed Navigators and Assisters program for helping individuals obtain coverage, the Exchange explored agent compensation alternatives to ensure that licensed agents can also play an important role for enrolling consumers in qualified health plans, and in the full range of new subsidized coverage options.

This Board Recommendation Brief addresses the role of agents in the individual market; the role of agents in the Small Business Health Options Program (SHOP) is addressed in separate brief.

Background

Health insurance agents have historically played a pivotal role in helping employers and consumers choose and enroll in health insurance products. Agents help consumers understand the complexities of health insurance, and guide them through the myriad of options to find an appropriate plan that best suits their needs. Agents can be a valuable resource to consumers and can play a key role in the success of the Exchange. Individuals who access the enrollment process for the Exchange may be eligible for subsidized or unsubsidized Individual insurance coverage, or may be eligible for Medi-Cal or Healthy Families, depending on their income level and family circumstances. It is also likely that some families seeking coverage through the Exchange will have some members who are eligible for one type of coverage (for example Medi-Cal) while other members of the same family are eligible for another type of coverage. Consequently, the enrollment process should consider this full range of potential enrollment, and should be as seamless as possible for the enrollee.

Federal regulations do not require state Exchanges to create a system that allows agents to enroll people in the Exchange. Rather, states have the *option* of allowing agents to provide enrollment assistance. They also have the option of allowing agents to help consumers apply for advance payment of premium tax credits and cost-sharing reductions.

Additionally, California's investment in The California Healthcare Eligibility, Enrollment and Retention System (CalHEERS) project will eventually simplify enrollment processes by providing a "one-stop shop" to determine eligibility for non-subsidized coverage for individuals in the Exchange and subsidized coverage for individuals eligible for various state programs. CalHEERS is jointly sponsored between the California Health Benefit Exchange, the Department of Health

Care Services, and the Managed Risk Medical Insurance Board, with the assistance of the Office of Systems Integration.

Under current practice, agents generally fall into two categories: those who are self-employed or work for an independent agency, and those who are "captive agents," who are employed by a carrier and may receive a salary. All agents are typically paid sales commissions that are higher in the first year of a new sale, but continue to accrue each year the individual remains enrolled. This commission is typically a percentage of the premiums paid by the enrollee or policyholder. There may also be incentive programs or volume triggers that change the commission rate or pay a bonus above a specified number of new sales or total premium value of an agent's book of business with a given carrier. This has implications for the Exchange in its objective to establish policies that assure unbiased representation of Qualified Health Plan products to individuals. There are commonly also commission incentives for combined sales of supplemental dental and life products for individuals.

While agents have and will continue to play a pivotal role in helping many individual Californians find and enroll in health insurance coverage, their function will evolve with the many changes that will occur effective 2014 with the implementation of the Affordable Care Act. Examples of those changes include:

- **Guaranteed Issue**: Under the Affordable Care Act, health insurance companies will be required to offer coverage to everyone regardless of health status and with no screening based on pre-existing conditions. Currently, one of the important roles played by agents is to help consumers navigate the complex issues related to qualifying for coverage and potential coverage exclusions.

- **Standardization of Essential Health Benefits**: All health plans, both inside and outside of the Exchange, will be required to offer products with at least the standard set of Essential Health Benefits. For consumers, there will be a far clearer set of comparable standards of covered benefits across health plans and products.

- **Implementation of Medical Loss Ratio Standards for Health Plans:** Effective January 1, 2011, health plans in the individual market were required to spend at least 80% of the premium collected on health care services. Non-health care services include health plan administration, marketing (including payments to agents), overhead and profit. To the extent plans spend less than the target amount on health care, the plan must pay that amount to individual enrollees as a rebate.

- **New Cost Sharing and Standards for Actuarial Value:** All health insurance products, both inside and outside of the Exchange, will need to offer benefits based on "actuarial value" standards related to cost sharing arrangements. This will also make comparison of plan designs simpler for the consumer. The Exchange is considering whether to establish a set of standardized benefit designs that all Qualified Health Plans must offer, and the range of variation in plan designs that will be permitted in the Exchange.

- **Opportunities for Premium and Cost-Sharing Subsidies**: Millions of Californians will have subsidies available for them to help make health coverage more affordable. In addition to expanded coverage through Medi-Cal and Healthy Families, federal subsidies will also consist of tiered financial payments based on income level to support the purchase of private plan options through the Exchange.

- **Responsibility to Purchase Insurance:** The Affordable Care Act mandates that nearly all individuals have insurance coverage or pay a penalty. Consequently, large numbers of individuals are expected to be newly covered in 2014.

These changes are expected to encourage a large number of individuals to seek insurance coverage for the first time, and others who are currently insured to assess whether there are new options available to them for broader coverage provisions or lower premium. Taken together, these changes will result in many people seeking the assistance of Agents to assess their options.

Issues and Recommendations

Agents have historically played an important role in assisting individuals in enrolling in Individual health insurance and are expected to continue do so once the Exchange becomes fully operational in 2014. The Exchange recognizes that agents can and should play an important role in promoting Exchange products in the individual market. This "Individual Market: Agent Payment Options" brief presents three options for payment to agents who facilitate enrollment of individuals in a plan offered through the Exchange, and potentially for other programs (see Table 1. Summary of Options for Agent Payment). Although there is an additional option of not compensating Agents for assisting Individuals to enroll in the Exchange, that option was dismissed. The three options related to potential agent payment are as follows:

- Option A. Plans Pay Agents (commission based on market terms)
- Option B. Exchange Pays Agents (commission structure that parallels market)
- Option C. Exchange Pays Agents as Navigators

Staff recommends that the Exchange establish policies that would allow for health plans in the Exchange to pay agents directly **(Option A)**. The rationale for this recommendation is outlined below, along with issues that require further investigation.

In a system in which health plans pay agents directly, plans would continue their own commission arrangements as the basis for payment to agents for enrolling individuals in Exchange products. Plans will also handle all administrative functions and ongoing costs associated with managing agents, and resolve any payment or compliance disputes. This option relieves the Exchange of the financial and organizational burden of developing the administrative resources to handle agent payments, and maintains the relationship between the health plans and agents with regard to their payment arrangements.

The Exchange would, however, need to establish clear policies in a number of areas, and has determined the recommended approach for several items. Others require additional consideration and are described in Table 2. Individual Market – Agent Payment Issues Needing Additional Development.

- **Define Agent Role with Non-Exchange Eligibility and Enrollment, including Medi-Cal and Healthy Families**: As discussed in the companion document on Navigators and Assisters, treating agents as "Direct Benefit Assisters," means certifying agents that have completed training with the Exchange. Eligibility for a potential subsidy in the Exchange can only be determined by a process that also first determines if an individual is eligible for Medi-Cal or Healthy Families. Because of this, agents would need to understand the full range of eligibility rules to assist individuals. Beyond assisting anyone on the basics of eligibility, the Exchange would require that Agents assist Medi-Cal and Healthy Families eligible individuals in completing their enrollment in those programs. They would provide the same full scope of counsel and advice as would a Navigator, but would not receive compensation for this service. The arrangement would be considered a cost of doing business with the Exchange, and would be consistent with current practice, whereby Agents often assist individuals in enrolling in Healthy Families with no direct compensation. This process will be facilitated through the CalHEERS project that will combine enrollment processes.
- **Require Commission Parity Inside and Outside the Exchange**: This option allows plans to base compensation for the sale of Exchange products on market commission rates. But to ensure there are not incentives for agents to sell outside of the Exchange, it is suggested that there be a contractual requirement on plans in the Exchange to pay equal commissions for the sale of non-Exchange products. Creating parity in commission rates between sales of Exchange and non-Exchange plans both reduces incentive for agents to steer consumers toward or away from the Exchange. (Note: it is clear that parity should exist for commissions related to Qualified Health Plans, but whether the parity should relate to non-QHP products offered by plans outside of the Exchange requires additional investigation).
- **Payment of Web-Based Agents**: Staff recommends that web-based insurance agents be compensated in the same manner as other agents. One example of a web-based agent is e-Health Insurance. Staff believes that all available enrollment options should be available to Exchange enrollees, and that one type of provider should not be advantaged or disadvantaged compared to any others.
- **Payment of General Agents**: Staff recommends that additional payments not be made to General Agents for Individual enrollees. Although there is a separate recommendation that General Agents receive payment for assisting with Small

Employer enrollment in the SHOP Exchange (this issue is discussed in a separate Board Recommendation Brief) the services required for Individuals are different from those needed by Small Employers, and staff do not believe such additional compensation is appropriate for the Individual Exchange.

- **Assuring Consumers' Access to Unbiased Information and Vesting of Agent Commissions:** It is critical that the Exchange's Agent policy be structured to ensure that all individuals have the full range of information presented to them in an unbiased way. Consequently, the policies must include an obligation that Agents present all health plan and product choices to potential enrollees in a fair and balanced way, regardless of the level of compensation an Agent receives from different health plan issuers. Agent compensation for incentive programs and some vested arrangements may be out of line with this requirement, and the Exchange will need to monitor compensation arrangements to ensure there is no bias introduced in how different health plan options are presented to enrollees.
- **Defining Scope of Agent Training/Certification:** All Agents must meet California Department of Insurance licensure standards that include training requirements. Those standards will need to be updated to reflect new market rules that will apply to Exchange and non-Exchange plans – such as Essential Health Benefits, guaranteed issue and actuarial value. The Exchange will also would need to develop curriculum and training that are specific to licensed agents that reflect the full range of training the Exchange considers important, including specific training on eligibility for subsidies and Exchange coverage. Mechanisms will need to be established to verify Exchange certification and licensure, ensure continuing education, and implement any other agent guidelines set forth by the Exchange. Whether this would be done by the Exchange or health plans needs to be investigated.

The Exchange received stakeholder feedback on these issues as well as those detailed in Table 2.

Considerations for Options Not Recommended

This Brief also considered the option of the Exchange paying agents directly (Option B). This was ultimately rejected due to the administrative burden it would place on the Exchange and the potential for creating instability in the marketplace. If the Exchange set agent compensation at a lower or higher rate than market commission rates, the result would be an unbalanced playing field between products offered inside and outside of the Exchange. For example, if the Exchange were to pay agents less than prevailing commission rates, agents may prioritize sales of non-Exchange plans for which they receive higher compensation, thereby jeopardizing sales of Exchange products.

In Option C, agents would be paid on the same basis as Navigators. Because Navigators will serve a different role than agents in the Exchange, linking the payment of Agents to that of

Navigators is deemed inappropriate. In the preamble to the final rule, HHS distinguishes the Navigator role from the role of agents. HHS states:

> "The responsibilities of a Navigator differ from the activities of an agent or broker. For example, the duties of a Navigator described under §155.210(e) of the final rule include providing information regarding various health programs, beyond private health insurance plans, and providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange. Moreover, any individual or entity serving as a Navigator may not be compensated for enrolling individuals in QHPs or health plans outside of the Exchange. As such, an agent or broker serving as a Navigator would not be permitted to receive compensation from a health insurance issuer for enrolling individuals in particular health plans."

Therefore, agents would in effect have to forego their commercial health business to serve as Navigators in the Exchange – an option that was determined to be unworkable.

Table 1. Summary Individual Market: Agent Payment Options

Option A. Plans Pay Agents (Market Commission)	Option B. Exchange Pays Agents (Set Commission)	Option C. Exchange Pays Agents as Navigators
SUMMARY The Exchange allows plans and agents to determine mutually acceptable contracts and commission, plans pay agents directly. Agents would need to be "certified" with the Exchange as Direct Benefit Assisters and meet terms (see Navigators and Assisters Recommendations, May 18, 2012).	**SUMMARY** The Exchange pays agents directly and sets the compensation rate for agents who enroll consumers in Qualified Health Plans, and potentially for assisting consumers in eligibility and enrollment processes for other programs.	**SUMMARY** The Exchange contracts directly with agents who enroll individuals in Exchange coverage and pays them the same as it pays Navigators.
PURPOSE Plans use health plan commission structures to compensate agents, and assume full responsibility for administrative functions and ongoing costs associated with agents. The Exchange minimizes its direct relationship with agents and delegates all payment negotiations to the plans. Agents would be required to obtain certification and training on Exchange products as "Direct Benefit Assisters."	**PURPOSE** The Exchange maintains a robust and engaging role in the oversight of agents by designing its own agent payment system. The Exchange enters into direct contracts with agents, and assumes responsibility for their training, appointment, certification, and assuring they are licensed.	**PURPOSE** The Exchange compensates agents at the same rate as Navigators and prohibits agents from accepting payment from the plan and the Exchange for the same sale. Under this scenario, agents who contract with the Exchange are prohibited from retaining direct contracts with plans.
PROS ▪ Minimizes financial and administrative burden to the Exchange ▪ Potential cost savings from utilizing existing infrastructure and administration ▪ Agents continue to receive market rate commissions ▪ Plans can adjust compensation to market changes ▪ The Exchange avoids being viewed as the driver of any future payment changes ▪ Exchange could still require new guidelines to control quality of sales by agents to enrollees	**PROS** ▪ Direct engagement with and oversight of agents ▪ Flexibility in payment design could result in cost savings ▪ Exchange could develop guidelines for agent participation ▪ Possible elimination of vesting arrangements may result in new enrollment in the Exchange. ▪ Top sellers of Exchange coverage could be rewarded as incentive to promote Exchange products	**PROS** ▪ Would promote equal offering of all Exchange products. Agents would be required to work with all Qualified Health Plans, which would remove any incentive to steer consumers towards a particular issuer. ▪ May lower premiums for consumers, as agents in the Exchange would not receive sales commission

Table 1. Summary Individual Market: Agent Payment Options

Option A. Plans Pay Agents (Market Commission)	Option B. Exchange Pays Agents (Set Commission)	Option C. Exchange Pays Agents as Navigators
CONS ▪ Exchange oversight would be limited ▪ Agents would continue to equally offer products inside and outside of the Exchange (as opposed to focusing on Exchange products) ▪ High risk of agents steering consumers to plans with which they have any or better commission arrangements ▪ Vested Agent compensation arrangements for some plans may result in disproportionately high payments and encourage steerage ▪ May disadvantage Exchange Qualified Health Plans that do not have established Agent commission arrangements	**CONS** ▪ The Exchange functions as another distribution channel and would jeopardize sales if it were to seek to reduce or adjust agent payments to improve affordability ▪ The Exchange would have to establish a process to execute agent agreements, verify their licensure and file appointment notices with CA Department of Insurance. ▪ Administrative and financial burden placed solely on the Exchange ▪ May negatively impact agent's existing relationships with plans ▪ If the Exchange lags in implementing payment incentive programs or does not establish these programs, agents may prioritize new sales outside of the Exchange	**CONS** ▪ May adversely result in agents not participating in the Exchange at all, thereby lowering Exchange enrollment ▪ Could result in adverse selection, as Agents selectively encourage preferred risk enrollees to plans from which they receive higher compensation ▪ Would potentially result in unequal payment rates for the sale of health insurance products inside and outside of the Exchange

Table 2. Individual Market – Agent Payment Issues Needing Additional Development	
Issue	**Consideration**
Navigators and Agent Payment Coordination	The Exchange must make certain that agents are not dually paid by plans as agents and by the Exchange as Navigators. Therefore, plans must work with the Exchange to develop a continually updated list of Exchange-eligible agents to prevent accidental dual compensation.
Plan Contracts with Agents	The Exchange having payments made directly by health plans allows current contracts between health plans and agents and General Agencies to remain intact. There may need to be amendments of those contracts to include guidelines for the sale of Exchange products.
Variation in Payment Amounts and Methods: ▪ **Graded payment schedules** ▪ **Adjusted payments based on agent volume** ▪ **Recognitions of high-performing agents** ▪ **Special promotions**	The proposal of having payment parity for Exchange and non-Exchange sales is complex given the variety of ways the agents are compensated and incented by health plans. The Exchange needs to investigate the range of payment methods and work with health plans and agents to structure a balanced program and to ensure those existing policies don't interfere with the requirement that all Exchange plans be presented to potential enrollees in an unbiased way.
Establish Agent Participation Rules	The Exchange may need to encourage plans to standardize their agent participation rules insofar as agents are working with Exchange QHPs.
Transparency of Agent Payment	The Exchange needs to consider the extent to which it makes agent commissions transparent to consumers.
Impact and Coordination with SHOP Operations	The Exchange will need to consider how and in what ways the small employer health options (SHOP) operational issues require coordination (e.g., tracking of payments to agents from different sources; would individual members keep the same ID if they transition from employer-based coverage to being COBRA-eligible; the role of agents in enrolling family members of SHOP employees in the individual Exchange).
Supplemental Product Sales	The Exchange will need to develop policies regarding potential agent involvement in the sale of dental and/or vision plans if they are offered as independent/supplemental products in the Exchange.

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Small Employer Health Options Program (SHOP) Agent and General Agent Strategy

Summary

The California Health Benefit Exchange is exploring approaches to assure the most effective outreach and enrollment in both its individual and SHOP exchanges, including how best to engage agents. Agent engagement and the structure of agent payments have important implications for sales and distribution of both the individual and SHOP exchange products. Based on prior market experience and the significant proportion of small group sales that are administered through agents, the role of agents is considered particularly critical for the SHOP exchange. Because of the wide agreement regarding the need for agent policies to be largely consistent with the small group marketplace, this "SHOP Agent Strategy" Board Recommendation Brief focuses on various options surrounding ***how*** to administer SHOP commission and compensation payments, rather than if they should be used. It should be noted that there are parallel issues and potentially different recommendations to consider for the Individual Exchange.

While not submitted for board action, the Exchange will also be considering the extent to which general agents participate in the SHOP Exchange. Currently, general agents contract directly with the plan issuers who also compensate them for services. This important relationship requires additional investigation before a board recommendation can be fairly prepared.

Background

The structure of agent compensation in the California Health Benefits Exchange will have a major impact on the enrollment of small businesses in the SHOP. If the rate is above market norms the SHOP may attract some existing groups, but may raise concerns among participating carriers. Paying higher rates would also increase SHOP costs. If the rate is below market norms, agents will likely not promote the SHOP Exchange. These commissions and potential General Agent (GA) load affect the overall affordability of Exchange plans. Like the Exchange, General Agents aggregate information and products and considerably expand access to the agent community.

Small group plans in California generally compensate agents and general agents at the same level (currently 7% and approximately 2 to 3%, respectively), with some plans paying slightly less. Some issuers are also moving toward models that decrease commissions in later years, and that pay a flat fee that increases with general inflation rather than medical inflation. Agents are generally compensated at a higher percentage level for individual sales than small group, ranging from 9 to 15%, with increased rates linked to volume, and on a descending scale for renewals. Historically, these higher rates of compensation have been attributed to the wide variation in products, the individual health underwriting and more intense ongoing customer service provided. However, these rates have been trending lower in conjunction with the Medical Loss Ratio requirements and the anticipated standardization of products due to clarification of Essential Health Benefits and the actuarial valuation of the metal level designs under the Affordable Care Act.

General Agents assert that the turnover rate among agent-aided sales is lower than direct sales, often because consumers also rely on these agents for their property and casualty coverage.

Agents also function as benefits administration support for small businesses which often do not have dedicated human resources support. Beyond providing rate quotes, they may advise on benefit design options, contribution strategy, interpretation of benefit coverage rules, and resolution of administrative and claims payment issues. They may provide ongoing support for enrollment changes and process coverage status changes through health plan eligibility and enrollment Web portals.

While the agent load has a material effect on premium and overall affordability, prior attempts to eliminate or reduce commissions have had a severe impact on sales. In its initial implementation the Health Insurance Plan of California (HIPC) paid lower commissions and in a different structure than was common in the market and alienated many agents by attempting to limit fees, and then subsequently introduced flat rate fees that were much lower than the prevailing commissions paid directly by health plan. This ultimately reduced potential sales volume and may have adversely impacted the risk mix of the Exchange.

Among California plans, Anthem and Kaiser manage a considerable volume of direct individual sales through an embedded sales organization. Kaiser builds their commission costs into premium on a community-wide basis. Although PacAdvantage had direct sale accounts, it eventually established a policy to assign groups to agents as small groups required significant resource support during open enrollment and major provider/carrier terminations. CalChoice[1] also refers all potential direct sales to an agent. Attempts by carriers such as PacifiCare (subsequently acquired by UnitedHealthcare) to drive small employer business to online sales in the mid-1990s also met with great resistance. The Exchange will need to determine whether all small groups will be required to use agents, or whether direct sales will be an option for those who prefer not to work with an agent.

Payment to agents is generally issued on a monthly basis through electronic funds transfer with a summary remittance to the agent. When a General Agent is involved, payment is routed

[1] CalChoice is a small group purchasing pool operated by Choice Administrators, a subsidiary of the general agency Word and Brown.

through the General Agent, which aggregates information across carriers and issues a consolidated payment and report to the individual agents. All plans use General Agents, but the contracting relationships with Anthem Blue Cross and Blue Shield of California are held uniquely, such that a General Agent would contract with one or the other, but not both Blues. The General Agent load is typically an additional 2% to 3% on top of the agent commission. General Agents typically pass through the published agent fee for small group sales but split the commission on individual sales to account for support or other purchased services. Related to the discussion on small employer benefit administration services, General Agents may serve as an aggregator (e.g., LISI) or owner (e.g., Word and Brown) of such services and offer packaged products to agents and their small business clients. Depending on individual agent sales volume, the General Agent may absorb the fees for such services.

Stakeholder Viewpoints

Health plans and agents are generally universal in the belief that the Exchange should assure continued use of agents in the small employer market "consistent" with market practices. Health plans and agents were very opposed to the Exchange having each plan pay agent commissions for members enrolled through Exchange. Due to the lag time in enrollment and eligibility confirmation, health plans would pay for Exchange enrollees at least one month behind payments to agents who sold their product directly. Agents and General Agents noted that such a payment process would be cumbersome and a disadvantage the Exchange. Both stakeholder groups cited reconciliation and bookkeeping challenges, with health plans noting that payment disputes may surface 6 months or more after the fact. Both stakeholder groups also felt that an Exchange role in paying producers was important for marketing purposes, and that the visibility of the Exchange as a payer would be lost in a remittance report.

Consumer advocates and others have noted that while agents play a critical role for the majority of small businesses, there is a significant portion of small businesses that do not use – and potentially do not trust – agents. In a survey conducted by Pacific Community Ventures among 804 small business owners, 27% of businesses say they will still continue to purchase insurance directly through their agent, and 43% anticipate a combination approach of using both the Exchange and their agent. Among the 25% that do not use agents, they trust small business organizations and non-profits as sources of information. The study notes also the need to provide alternative sources of information, particularly for businesses with a large portion of Hispanic employees.

The following issues have an important bearing on the design of agent payments:

- The Affordable Care Act and subsequent exchange regulations establish that health plan pricing outside the Exchange must match pricing inside the Exchange, which may have a bearing on how selling, general and administrative ("SG&A") expenses are spread across products.

- The Affordable Care Act also establishes that Navigators will be used to provide educational support to assist new enrollees in Individual plans and that Navigators cannot receive agent commissions.

While Navigators cannot receive payments from health plans for SHOP enrollment, they can be compensated by the Exchange. The Exchange could also facilitate referrals to agents to complete the sales process and provide programmatic information and orientation materials to the small business.

Options

The table that follows the recommendations discussion details the options related to engaging agents and General Agents in the SHOP for consideration by the Board.

Options for Agents

- Option A1: Grant market competitive commissions with the Health Plans issuing payment to agents;
- Option A2: Grant market competitive commissions with the Exchange issuing payment to agents;
- Option A3: The Exchange sets rates and issues payment for agents.

Options for General Agents:

- Option B1: SHOP excludes General Agents from distribution;
- Option B2: SHOP contracts with some General Agents through a bid process (2-4 General Agents);
- Option B3: SHOP contracts with all qualified General Agents

Recommended Approach

Staff recommends Option A2 (Exchange grants market competitive commission and pays) with additional considerations noted below. Both options include General Agents as part of the distribution channel. Options such as the exclusion of agents and the use of new group bonuses to encourage sales through the Exchange were considered and rejected due to their potential negative impact on stakeholders and distribution channels for the Exchange.

Under Option A2, the Exchange would reinforce its role as aggregator and could use the payment process to market its services and reinforce the value of the Exchange to its distribution channels. A key consideration under Option A2, whereby the Exchange pays commission consistent plan rates, is that it entails administrative resources and complexity of matching health plan fee schedules on a real time basis, including downgrades and occasional PMPM compensation structures. Additionally, to the extent that health plans hold direct contracts with agents and General Agents, it could be challenging for the Exchange to administer different practice standards across plans. Additionally, the Exchange would need to work with carriers to assure that agents are certified to meet each carrier's requirements or establish a mechanism to amend such agreements to allow agents to "accept assignment" from the Exchange.

Staff recommends Option B2 whereby the SHOP Exchange contracts with 2-4 General Agents through a bid process. Bidder criteria will be developed based on a series of factors like broad reach of agents (statewide or regionally); how they partner with the Exchange; General Agent override costs and technology, tools and value adds. While general agents currently play a significant role in the sales and enrollment of small business health insurance, the Exchange is also considering future needs and the challenges for plans issuers to meet new medical loss ratio requirements in 2014. Although the additional fee increases premium costs, the load on premium would hopefully be offset by the expanded access to agents and new enrollment volume. General agent compensation is expected to accrue toward health plan issuer's administrative expenses for MLR calculation, but how general agents are compensated by plan issuers may change between now and 2014.

Next Steps

Staff recommends that the Exchange develop, in consultation with potentially participating Qualified Health Plans and agents the following:

- Bid criteria for selection of general agents to leverage relationships and the agent network.

In developing these recommendations, staff will seek to both assure effective involvement of general agents and to minimize the cost load on small businesses. Staff will further develop how to address:

- Whether to offer direct sales, or how to assist employers who prefer not to work with an agent;
- How to best assist unrepresented small businesses, including those in start-up mode;
- The role of navigators in assisting small businesses to either generally understand the SHOP exchange or to enroll in the SHOP.

In addition, staff will need to further develop a range of operational issues related to implementing an agent strategy. Table 4 "Operational Considerations" highlights some of these issues and their implication for the options considered.

[3] Historically, PacAdvantage sales through General Agencies also represented larger group sizes, which were beneficial to the overall risk mix. Furthermore, the General Agency communications and sales delivery system was effective in PacAdvantage despite the additional cost.

Table 4: Summary of SHOP Agent Payment Options

Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
SUMMARY The Exchange would grant or require participating health plans to grant market completive commissions and have plans administer payments for members enrolled through Exchange plans	**SUMMARY** The Exchange would grant market competitive health plan commissions and issue payments directly to agents	**SUMMARY** The Exchange sets a rate based on prevailing health plan commission structures and issues payments directly to agents.
PURPOSE The Exchange leverages the prevailing health plan commission structures and may reduce the level of infrastructure and ongoing resources to manage agent support	**PURPOSE** The Exchange uses the prevailing health plan commission structures and leverages its visibility among agents by being the issuer of payment	**PURPOSE** The Exchange sets a common rate across health plans and supplemental vendors that leverages its visibility among agents but simplifies the administration of payment
DESCRIPTION The Exchange supports a level playing field among health plans and the SHOP program by granting market competitive rates or requiring participating plans to pay market competitive commissions. Any special incentive programs are simultaneously available through small groups sold under the Exchange, but the agent receives multiple payments from carriers depending on the distribution of the small group's beneficiaries	**DESCRIPTION** The Exchange supports a level playing field among health plans and the SHOP program by granting market competitive rates. The Exchange would require health plans to count Exchange enrollment towards individual agent incentive programs. By being the payer of record, the Exchange enhances its visibility among agents but also simplifies commission reconciliation by agents	**DESCRIPTION** The Exchange promotes itself as a unique entity with a market rate-based commission schedule. By being the payer of record, the Exchange enhances its visibility among agents. The Exchange would require health plans to count Exchange enrollment towards individual agent incentive programs. Additionally, the Exchange would negotiate participation agreements with General Agents who receive a load and in turn aggregate payments to agents

Table 4: Summary of SHOP Agent Payment Options

Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
PROS ▪ The Exchange minimizes its administrative burden; agent agreements and licensure verification are delegated to the plans ▪ The Exchange keeps health plans in the role of setting agent and General Agent commission levels and avoids the Exchange being viewed as the driver for any potential future payment changes ▪ Does not materially impact direct sales operations of health plans (Kaiser, Anthem), but potentially limits Exchange product exposure among the direct sellers ▪ Any vesting arrangements favored by agents and permitted by health plans would remain	**PROS** ▪ The Exchange increases its visibility among agents as the payer of record ▪ Using in-force commission rates limits potential gaming by agents to move business to optimize payment under incentive programs ▪ The Exchange reinforces its role as aggregator and simplifies billing administration and reconciliation for agents and General Agents ▪ The Exchange could build and reinforce agent relationships through referral of sales leads ▪ Any vesting arrangements favored by agents and permitted by health plans would remain	**PROS** ▪ The Exchange promotes itself and offers a simple payment design to agents and General Agents ▪ This approach reinforces the Exchange's role as aggregator and simplifies billing administration and reconciliation for agents and General Agents ▪ The Exchange could build and reinforce agent relationships through referral of sales leads ▪ The Exchange payment structure would likely supersede any vesting arrangements between health plans and agents ▪ The Exchange can require health plans to recognize Exchange volume as part of their incentive programs

Table 4: Summary of SHOP Agent Payment Options

Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
CONS ▪ The stakeholder response to this approach was overwhelmingly negative from health plans and agents for SHOP but viewed as acceptable for the Individual Exchange ▪ Plan payment results in lag time due to eligibility reconciliation ▪ Agents receive multiple payments from carriers for the same group, potentially at different times and payment reconciliation is difficult ▪ This approach may be difficult to operate with General Agents due to additional data collection and transfer times	**CONS** ▪ While the Exchange may require health plans to count new sales towards the volume incentives of individual agents, it is uncertain whether this can feasibly be administered if the sales incentives are linked to other plan-based products ▪ Management of variable rates, downgrade schedules and PMPM fees adds administrative costs ▪ If the Exchange lags in implementing payment incentive programs, agents may focus new sales outside of the Exchange ▪ The Exchange must establish a process to execute agent agreements and verify their licensure and other requirements	**CONS** ▪ The Exchange functions as another distribution channel and would jeopardize sales if it were to seek to reduce or adjust agent payments to improve affordability ▪ The Exchange could disadvantage those health plans with effective direct sales units (assuming that common product pricing would require the carrier to raise its direct sales pricing) ▪ The Exchange may place one or two carriers at a disadvantage (Aetna and Anthem Blue Cross) ▪ The Exchange must establish a process to execute agent agreements and verify their licensure and other requirements

Table 5: Summary of SHOP General Agent Payment Options

Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
SUMMARY The Exchange would exclude General Agents from its distribution channels	**SUMMARY** The Exchange would contract with 2-4 General Agents selected through a Bid Process	**SUMMARY** The Exchange would contract with all qualified General Agents.
PURPOSE The Exchange excludes General Agents from its distribution channels and provides more competitively priced SHOP products.	**PURPOSE** The Exchange leverages an existing distribution channel which in turn expands sales and marketing options to a significant number of agents who are associated with the General Agents.	**PURPOSE** The Exchange maximizes its available distribution channels by using all qualified General Agents.
DESCRIPTION The Exchange excludes General Agents but relies on Agents and navigators to support SHOP marketing and sales.	**DESCRIPTION** The Exchange selectively leverages an existing distribution channel. Bidder criteria will be developed based on a series of factors like broad reach of agents (statewide or regionally); how they partner with the Exchange; General Agent override costs and technology, tools and value-adds	**DESCRIPTION** The Exchange recognizes all qualified General Agents and establishes a standard commission schedule for General Agents. This allows the Exchange products to be included in sales and bid proposals that are produced through General Agent systems.
PROS ▪ The Exchange avoids additional commission load on its SHOP products. ▪ The Exchange minimizes its administrative burden.	**PROS** ▪ The Exchange manages its distribution channels more closely and sets performance expectations through its bid criteria. ▪ The Exchange ensures its load for General Agents is priced competitively. ▪ The Exchange expands access to a broader pool of agents. ▪ Selective contracting limits administrative burden on the Exchange (data management, premium and commission audits, etc.)	**PROS** ▪ The Exchange maximizes all available distribution channels.

Table 5: Summary of SHOP General Agent Payment Options

Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
CONS ▪ Limits access to a significant distribution channel for small group sales.	**CONS** ▪ Limiting the number of General Agents may result in exclusion of regional organizations that support underserved populations. ▪ Negative impact on General Agents who are not selected for the Exchange.	**CONS** ▪ Adds administrative and oversight burden on the Exchange. ▪ General Agents have significant variability in service capacity and systems support, which may add complexity to Exchange sales and marketing communications. ▪ May introduce quality control issues for the Exchange.

Table 6: Agent Payment[1] Operational Considerations

Issue	Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
Vesting (grandfathering historical contract arrangements and rate schedules which are higher than present market conditions)	Vesting would remain for legacy contracts.	While the Exchange could contractually limit new sales to current, in-force commission levels, it is not clear whether the Exchange could override direct plan-agent contracts if those contracts include vesting language. One policy approach could be that a legacy group moving into the Exchange would be subject to prevailing commission schedules, but this would be a disincentive for an agent to bring renewing business to the Exchange. If legacy fees were permitted, the Exchange would need to link individual members of the same employer group to different fee schedules.	The Exchange could establish as part of its contracts that only its in-force rates apply for all sales through the Exchange, and that fee schedules for new and renewing small groups are subject to modification by the Exchange. Agents would only be incented to sell new groups in the Exchange. To the extent legacy fees are higher, agents would not be incented to move that business anyway.
Role of health plans' captive agents (Direct sales programs operated by health plans independent of GAs, external agents and the Exchange).	This option would be least disruptive to health plan-based agents. While the Exchange could establish contract terms to require equal representation of Exchange-based products, it might be challenging to reinforce this in practice. Additionally, the amount of administrative premium load for Exchange products' would create a differential premium disadvantage for the Exchange.	The Exchange would have limited ability to market itself through these captive agents as there would be no added incentive to refer cases to the Exchange. However for subsidy-eligible individuals, plans should be motivated to support enrollment in the Exchange if they felt there was a likelihood of retaining the prospective member. The Exchange needs to consider seeking "fair marketing" rules as part of its health plan contract.	The Exchange would create competition with the plan-based agents who would not benefit from an outside commission schedule, and arguably could offer a similar product without the added commission cost. As part of its health plan contracts, the Exchange could formulate rules for referral of subsidy-eligible individuals and set expectations for training of internal agents on tax credits and Exchange options.
Graded payment schedules	This Option optimizes the ability to capture health plan-based schedules so as to not disadvantage Exchange products.	The Exchange would need to undertake potentially complex management of graded payment schedules and change payment based on the anniversary of subsequent renewal periods.	The Exchange could elect to adopt a graded payment schedule if that became common practice, but apply the schedule as a standard across all plans.

Table 6: Agent Payment[1] Operational Considerations

[1]This table below describes a range of operational considerations and implications for policy and implementation under each option. The table includes topics discussed in stakeholder interviews and is not intended to be an exhaustive list of operational issues.

Issue	Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
Adjusted payments based on agent volume	This Option optimizes the ability to capture health plan-based schedules. However, to the extent that subscribers from a single employer group split among carriers, a agent will be paid at different rates within the same employer group if volume incentives are achieved with one carrier and not another. An unintended consequence may also be that agents will steer members towards plans to maximize their compensation. This Option also allows the Exchange to best match agent payment designs in the Individual segment where tiered approaches are most common.	The Exchange would need to coordinate information with health plans to calculate the total volume of membership associated with the agent that may qualify that individual (or organization) for higher payment tiers.	The Exchange could establish incentive programs linked to Exchange volume or total plan volume. If linked to Exchange volume, health plans may have a concern about transfer of existing membership. The Exchange could also limit Exchange business to a fixed rate but require health plans to count SHOP volume in its internal reward programs for agents.
Adjusted payments based on employer group volume	This Option optimizes the ability to capture health plan-based schedules. However, to the extent that subscribers from a single employer group split among carriers, the Exchange would need to establish rules around premium thresholds and volume insofar as whether they apply at the plan level or employer group level. An unintended consequence may also be that agents will steer members towards plans to maximize their compensation.	If the Exchange permits groups that grow beyond 50 employees to remain in the Exchange prior to 2016, fee adjustments would need to be calculated for groups that produce more than $500,000 annual premium, if a plan has a total premium threshold trigger that reduces commissions.	The Exchange can establish a common policy for groups that grow beyond 50 beneficiaries consistent with general market practice. It should be noted that current practices vary with either a lower percentage commission or a rate that is triggered by $500,000 premium.

Table 6: Agent Payment[1] Operational Considerations

Issue	Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
Recognition of high-performing agents	The Exchange could channel new sales referrals to top Exchange sellers to reinforce its value with these agents.	The Exchange could channel new sales referrals to top sellers to reinforce its value with these agents independent of their volume of direct plan sales.	The Exchange could channel new sales referrals to top sellers to reinforce its value with these agents.
Match special promotions	This Option optimizes the ability to capture health plan-based special promotions in real time so as to not disadvantage Exchange products.	The Exchange would need to require prior notification from health plans. While it is desirable to automatically match special health plan promotions, these promotions often are linked to total volume and/or the sales of embedded supplemental dental, vision and life products. Because of the lag time in data transfer to reconcile step-based rewards based on volume and potential system programming resources to recognize commission changes, it would be difficult for the Exchange to administer a match program.	The Exchange would have flexibility in creating special promotional programs to market its programs or new products, but health plan concerns about transfer of existing membership needs to be recognized.

Table 6: Agent Payment[1] Operational Considerations

Issue	Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
Establish agent participation rules	The Exchange would need to encourage plans to standardize their agent participation rules and possibly facilitate global plan participation by requiring a "me-too" arrangement for transfer of licensure, financial and tax information. The difficulty is that some plans have more stringent requirements on bonding and E&O insurance at levels which could be problematic for small firm or individual agents. Additionally, there would need to be consistent rules for agent of record rules and adjudicating changes issued from the Exchange to occur in a common timeframe.	The Exchange could require that its contracted health plans maintain contracts with participating agents and validate licensure, continuing education or other requirements. To minimize burden additional among agents to contract with new QHPs, the Exchange could administer a common participation agreement and/or be delegated to hold such contracts by new QHPs. However, this would add administrative burden for the Exchange. Additionally, the Exchange would need to establish a financial relationship with agents, agencies and/or General Agencies for income-reporting. Additionally, the Exchange would need to manage reconciliation and audit processes to verify accuracy of payment, as well as address disputes about changes in the agent-of-record and accuracy of payment.	The Exchange would likely establish participation requirements and hold contracts with participating agents. As part of its contracting requirements, the Exchange could establish "fair marketing" requirements to represent all available plan options without bias. The Exchange would also undertake certification responsibilities such as license validation, W-9 reporting, etc. Additionally, the Exchange would need to manage reconciliation and audit processes to verify accuracy of payment, as well as address disputes about changes in the agent-of-record and accuracy of payment. In the future the Exchange could establish minimum sales requirements for agents.
Transparency of agent payment	The Exchange could potentially publish in-force rates similar to General Agencies, but it would be confusing to small employers to see different loads at a subscriber level on premium billings.	To the extent that the Exchange produces an aggregated bill for the small employer, it would be challenging to reflect inconsistent agent fees at a member level.	A common fee schedule lends itself to disclosure requirements and transparency goals.

Table 6: Agent Payment[1] Operational Considerations

Issue	Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
Role of General Agencies (GA)	The Exchange would recognize existing health plan and GA contract rates but there could be transparency and consistency issues for agents who use GA-based IT systems to produce rate quotes.	Health plans likely have variable contract rates with GAs based on performance and historical alignment. The terms of these contracts may be held confidentially and likely, the higher paid GA contracts reflect greater direct sales. By matching these rates, the Exchange would potentially have a level playing field, but in direct completion with carriers for their high producers.	The Exchange would set selection criteria and either set a fixed rate or negotiate a rate with GAs. The transparency expectations point towards using a fixed rate, but the benefit of fostering competition among the GAs would potentially be lost.
Impact on SHOP operations	This strategy minimizes plan operational support after initial set-up for enrollment and retrospective reporting. Service support would be required to resolve agent of record and/or payment disputes. It also requires a service liaison with each carrier and a mechanism to access to health plan reporting and coordination of review requests.	This approach requires significant resources to program differences from plan to plan, and recognition of commission downgrade schedules upon renewal or total volume. Resources would be required to document financial relationship with agents and GAs, and produce tax reporting. The Exchange should require electronic funds transfer for payment and issue online notification of remittance reports available for review and download. Service support would also be required to resolve agent of record and/or payment disputes.	Resources required to certify, contract with and report income for agents and GAs. Assumes initial application documentation required, annual attestation of license in good standing, with sample audits, and process for de-certifying agents. Assumes bulk of transactions conducted via electronic fund transfer and online notification of remittance reports available for review and download. Service support required to resolve agent of record and/or payment disputes.

Table 6: Agent Payment[1] Operational Considerations

Issue	Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
Impact on supplemental/ ancillary product sales	Option 1 would support an approach to offer supplemental benefits through health plan-based products so agents may count sales towards their plan bonuses. If the Exchange established direct vendor relationships, agents could be incented to sell outside of Exchange to optimize their plan-based bonuses.	Plans should be required to provide the Exchange with pre-notification (30-60 days) of producer incentive changes. It may be difficult to track external commissions on ancillary products because of the various combinations that are available through carriers and types of commission incentives added for supplemental benefit sales (see special promotions above). This option would support an approach to offer supplemental benefits through health plan-based products so agents may count sales towards their plan bonuses. If the Exchange established direct vendor relationships, agents could be incented to sell outside of Exchange to optimize their plan-based bonuses.	There is more variability in commissions for supplemental products so the Exchange would likely be looking at an average percentage rate, which could affect sales up or down. However, the total commission dollars associated with supplemental benefits is much lower than for health plans, so may not have a material effect.
Implications for internal Exchange-based agents	The Exchange could consider different internal compensation structures that include base salary and a full or reduced commission payment or link a bonus independent of commissions to total sales. Plan contracts could be structured to pay the direct Exchange sales commissions to the Exchange in the aggregate. If a matched commission is fully paid to internal agents, there may be an unintended consequence of promoting the higher paying plans.	The Exchange could consider different internal compensation structures that include base salary and a reduced commission payment or link a bonus independent of commissions to total sales. If a matched commission is fully paid to internal agents, there may be an unintended consequence of promoting the higher paying plans.	The Exchange could consider different internal compensation structures that include base salary and a reduced commission payment or link a bonus independent of commissions to total sales.
Implications for direct sales	The Exchange may manage directly through an internal sales unit with licensed agents with payments to the Exchange for customer service support.	The Exchange may manage directly or provide sales leads to General Agencies and agents as part of its engagement strategy	The Exchange may manage directly or provide sales leads to General Agencies and agents as part of its engagement strategy

Table 6: Agent Payment[1] Operational Considerations

Issue	Option 1: Match Commissions (Plan Pays)	Option 2: Match Commissions (Exchange Pays)	Option 3: Exchange Sets and Pays Commissions
Implications for design of Individual product commissions	This option could be feasibly implemented for the Individual Exchange product if the plan acts as initial entry point for premium collection. If the enrollment rules (e.g., effective date of hire, limits on retroactivity based on payment date) are the same for the Exchange as outside the Exchange, the timeliness or lag time in payment should be comparable.	If enrollment and premium collection is managed by the plan, then the Exchange may be in a situation of paying agents with a lag time, which would be negatively received. However, the value of the member subsidy in driving new sales may outweigh this concern.	Given the greater variability in the Individual market around volume and downgrades, an Exchange-specific rate would need to be competitive with major carriers' standalone products. However, this option also allows the Exchange to operate its own incentive design and special promotions.

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